Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CENTER FOR PAIN RELIEF
9080 HARRY HINES STE 110
DALLAS TX 75235

Respondent Name
Pacific Employers Insurance Co

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-12-0846-01

MFDR Date Received
November 14, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have provided the appropriate documentation to support the services billed. The carrier has denied payment in error."

Amount in Dispute: $273.73

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute received however no written response submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 3, 2011	Professional Services	$273.73	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.20 sets out procedures for insurance carriers upon receipt of medical bills.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - X901 – DOCUMENTATION DOES NOT SUPPORT LEVEL OF SERVICE BILLED.
   - Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
   - U849 – THIS MULTIPLE PROCEDURE WAS REDUCED 50% ACCORDING TO FEE SCHEDULE OR USUAL AND CUSTOMARY GUIDELINES
   - X263 – THE CODE BILLED DOES NOT MEET THE LEVEL/DESCRIPTION OF THE PROCEDURE PERFORMED/DOCUMENTED. CONSIDERATION WILL BE GIVEN WITH CODING THAT REFLECTS THE DOCUMENTED PROCEDURE.

Issues

1. Is the disputed services supported by documentation?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services with reason code X901 - DOCUMENTATION DOES NOT SUPPORT LEVEL OF SERVICE BILLED. The American Medical Association (AMA) CPT code description for 62284 as Injection procedure for myelography and/or computed tomography, spinal (other than C1-C2 and posterior fossa) and 77003 as Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid) Review of the submitted documentation finds procedures not identifiable in "Operative Report" Carriers' denial is supported.

   The carrier denied the disputed service with reason code X263 – THE CODE BILLED DOES NOT MEET THE LEVEL/DESCRIPTION OF THE PROCEDURE PERFORMED/DOCUMENTED. CONSIDERATION WILL BE GIVEN WITH CODING THAT REFLECTS THE DOCUMENTED PROCEDURE. The American Medical Association (AMA) CPT code description for Procedure code 95971 as Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming. Review of the submitted documentation finds the Carriers' denial is supported.
2. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		December 18, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.